Representing community providers of services and supports for children and adults with intellectual / developmental disabilities, mental illness and other disabilities.

January 22, 2014

Doug Elwell
Managing Principal
Health Management Associates
9000 Keystone Crossing, Suite 550
Indianapolis, IN 46420

RE: IARF Comments on Draft 1115 Medicaid Waiver Application

Mr. Elwell:

IARF is a statewide association of community-based providers serving children and adults with intellectual and developmental disabilities, mental illnesses, and substance use disorders. Our members provide services in over 900 locations throughout Illinois, from Galena to Karnak, and from Quincy to Danville. For over 35 years the Association has been the voice of community-based services and supports to state government.

To provide context to the comments we provide below, it's important to share with you that our member agencies provide services and supports outlined in four 1915(c) waivers (Adults with Developmental Disabilities, Children with Developmental Disabilities - Residential, Children with Developmental Disabilities - Support, and Persons with Brain Injury); ICFDD (ICF/MR) services; the Medicaid Rehabilitation Option (59 Ill Adm Code 132); and grant funded/contractual services (respite, case coordination, supervised, supported, and crisis residential, and permanent supported housing). Most, if not all, of these services are funded in the Department of Human Services' budget and currently receive Medicaid match from the federal government.

An 1115 Medicaid Waiver presents a significant opportunity for Illinois to draw down additional federal dollars and invest those dollars in community-based services and supports for children and adults with intellectual and developmental disabilities, mental illnesses, and substance use disorders. These federal dollars, if utilized appropriately and in collaboration with community stakeholders, could advance Illinois' rebalancing efforts towards person-centered community-based care through addressing infrastructure needs and gaps in wraparound services and supports.

On behalf of our 85 member agencies, we appreciate further opportunity to provide comments, questions, and recommendations on this effort. As partners with families and the state of Illinois in ensuring the long-term services and supports of the adults and children our member agencies serve are high-quality and person-centered, we believe the following comments should be considered carefully and the recommendations included in the final draft of the 1115 Medicaid Waiver application submitted to the Centers for Medicare & Medicaid Services (CMS).

Comments/Concerns/Questions:

- While the 1115 Medicaid Waiver outlines general positive outcomes for individuals enrolled in the Medicaid program, it is clear having reviewed comments on the concept paper, that advocates, providers, and other stakeholders representing the interests of individuals with intellectual/developmental disabilities lack assurances this process will guarantee person-centered services and supports.
- The Background/Overview Section notes that the State has learned through consent decree

Janet S. Stover, President / CEO
Illinois Association of Rehabilitation Facilities, Inc.
206 South Sixth Street
Springfield, Illinois 62701
Phone: (217) 753-1190
Fax: (217) 525-1271
www.iarf.org

implementation and Money Follows the Person (MFP) of the need to strengthen the community infrastructure. The community would benefit from the State sharing what these implementation processes have revealed.

- While no Medicaid State Plan benefit changes are anticipated in this application, we note modifications to service definitions from those existing in current waivers - specifically the definition of residential habilitation. These changes are a point of concern. Furthermore, has the State considered making optional services mandatory, such as preventative and enhanced dental services for adults with ID/DD?
- While the application does not expressly endorse or oppose Medicaid managed long-term services and supports (MMLTSS) under traditional managed care programs (HMOs), we recommend the Administration not approach this model until alternative models - such as Care Coordination Entities (CCEs) and health homes - including specialized health homes with behavioral health and ID/DD designated providers - are fully explored and tested. The application should prioritize these models over traditional MMLTSS, which has not proven in other states to improve health outcomes and reduce costs.
- The Application references the newly established Innovation and Transformation Resource Center aimed at providing technical assistance for health system transformation. It is unclear how this office will be staffed and whether it will include individuals well-versed in community-based models of care or whether it will be mandated to coordinate with service providers with expertise in this area.
- Health plans, providers, and other stakeholders are actively working on legislation to review the State's existing authorized telehealth activities. It is unclear if the draft application takes these discussions into account.
- Under the Health Care Workforce Loan Repayment Section, specific reference is made to safety net hospitals that struggle with training costs and high turnover. This has always been a critical issue faced by community-based service providers, as these organizations serve - almost exclusively - Medicaid enrollees, but do not benefit from DSH payments to help offset costs. Therefore, we would oppose bonus payment pools for hospitals, Medicaid GME, and other approaches that would have the effect of further destabilizing the direct service personnel workforce in the community, which shares overlap in areas of nursing and other qualified professionals. With that in mind, we would support discussions about establishing a loan repayment program that includes community-based provider organizations.
- The Association supports commitments to fund existing loan repayment programs for specialists (such as psychiatrists) and also supports the commitment to review existing programs for the potential inclusion of other professionals if appropriate.
- The section discussing Regional Health Hubs and public health integration begs the question as to how many individuals with ID/DD and SMI access health services from local health departments and FQHCs, and where a premium add-on payment might encourage addressing the specific service needs of these populations.
- Under the Current Health Care Workforce and Projected Need Section, reference is made to 64.9% of Illinois physicians accepting new Medicaid patients in 2011, compared to the national average of 76.4%. In terms of the scope of waiver effort, can the State produce data specific to the number of physicians seeing new Medicaid patients diagnosed with ID/DD and/or SMI?
- As indicated in our comments on the concept paper, we see value in eliminating barriers in our current waiver structures so that true person-centered supports can be achieved for the individuals and families our members serve. We believe five of the six points outlined on page 31 should be supported (reduce administrative complexity, rationalize service arrays, increase flexibility and choice, support development and expansion of community options, and reduce/eliminate the waiting list for services).
- Under the current waiver structures, few providers have the ability to provide needed wraparound services due to fee-for-service limitations and/or funding limitations. Addressing this issue, particularly for individuals dually diagnosed with an intellectual/developmental disability and a mental illness, is necessary.
- In our comments on the concept paper, we noted we were unclear how a universal assessment tool (UAT) could meet the needs and wants of all Medicaid enrollees, and at the same time interface with determining rates and reimbursements for services. These concerns have not been addressed in the draft application. Who would perform the assessment? What role will case managers and service coordination agencies play? Furthermore, we note the document gives the impression that the State has not determined whether existing assessment tools (such as ICAP and LOCUS) or elements of these tools absolutely will be included in the UAT. Should a UAT include assessments of individuals

with ID/DD and SMI it will be important to review instruments standardized for use with the given population.

- The draft application indicates the State is working on a reimbursement rate methodology to coincide with the consolidation of the HCBS waivers, but that will also include children and youth that meet eligibility for behavioral health services. There are several rate and reimbursement methodologies currently in place - some outlined in law, some in regulation, and some not at all. We are curious how a single methodology will meet the stated goals of reducing and/or eliminating service-level variability and disparity across populations with the needed focus on person-centered supports.
- The section on Expanded Service Array references service level tiers assigned budgetary ranges increasing based on functional needs. It also notes the same array of services will be available to individuals in all tiers regardless of disability. From the viewpoint of ensuring wraparound services are available, this approach has merit. However, from the viewpoint of funding true person-centered supports, the concept of tiered service levels with assigned budgetary ranges is a cause of concern without further explanation. For example, we've heard concerns from the provider community in states that have developed a tailored Support Intensity Scale (SIS) not adequately funding person-centered supports. Will there be flexibility in the tiers or movement among them should an individual require more or less intensive supports? Will there be geographic variances? **The lack of detail regarding service tiers is a point of concern that requires further clarity.**
- As the organization that initiated legislation establishing a cross-disability database in Illinois, we support efforts to take a hard look at our current Prioritization for Urgency of Need for Services (PUNS) for revision. However, we caution against revisions that might inappropriately remove individuals from the waitlist.
- While we acknowledge the commitment to working with providers and other key stakeholders on Quality Incentives and Outcomes, the lack of clarity in this section remains a point of major concern. How would the State fund this approach: redistribute existing resources? Identify new resources? Would providers be financially rewarded for meeting outcomes or would funding be reduced? As the systems-level improvements identified in the application are all influenced by several factors, not the least of which is rates and reimbursements, this section requires further clarity.
- As a diverse organization that strives to meet the employment needs of individuals with intellectual/developmental disabilities and mental illnesses with diverse wants, needs and skills, we have articulated principles regarding employment. In terms of moving forward with Employment First implementation, we do not see a vision as to how the Administration intends to address barriers to integrated employment, especially in more rural areas of the state.
- Consistent with our concept paper comments, we support efforts to integrate behavioral health services and supports, including the establishment of behavioral health homes.
- The Behavioral Health expansion and integration section references a requirement on providers outside of managed care regions to comply with a series of integration mandates. We note it is likely these providers will be in rural, non-populace areas of the State in which there is a dearth of health care providers, transportation services, etc. It is not recommended the State require mandates of these providers without somehow incentivizing their development.
- The Association did not support provisions within recent legislation proposing to convert Institutions of Mental Disease (IMDs) to Specialized Mental Health Rehabilitation Facilities (SMHRFs). Furthermore, we do not support the State's request to waive the IMD exclusion for these facilities. We believe such an approach is detrimental to the State's efforts to reduce institutionalization of individuals with serious mental illnesses.
- We support increased access to Assertive Community Treatment (ACT) and Community Support Teams (CST) for the purposes stated in the draft application.
- As outlined in our comments on the concept paper, we support expanding access to supportive housing and other models that ensure the housing continuum of care, including use of incentive-based payments.
- We also support the commitment to include children's behavioral health services and supports in the waiver application.
- Encouraging MCOs and MCCNs to consider alternative non-State Plan services, such as housing and related supports, has merit. We recommend expanding on this approach to include contract language with CCEs as well as to encourage availability of other needed services that are in the State Plan, such

as dental and psychiatry, which are barriers to successful health outcomes for persons with intellectual/developmental disabilities and mental illnesses.

- The explanation of budget neutrality regarding the waiver continues to elicit confusion. Stakeholders have difficulty syncing the commitment to expanded access to community services with an understanding that the waiver must be budget neutral. Consider the following realities that exist in our current system:
    - Inadequate rates and reimbursements for existing services that have never kept pace with inflation, don't address the growing cost of fringe benefits, and do not fund true person-centered services and supports;
    - Variable rates for individuals transitioning from state-operated developmental centers (SODCs) to the community and those receiving services under the current waiver;
    - Lack of clarity as to whether SODCs are included in the waiver;
    - Necessary investments to transform the options for all individuals currently supported under the waiver;
    - The lack of data with respect to cost estimates, CNOM totals, etc. is a point of confusion.

  This gives the impression of service rationing and/or funding reductions for community-based services in the Medicaid program. **<u>These are significant concerns that require further clarity.</u>**
- In addition, the current draft application, while appropriately outlining reinvestment of resources in the community-based mental health system, does not appear to do so for the community-based ID/DD system.
- References to a provider tax on residential habilitation providers are too vague and remain a point of concern for IARF members.
- While the Association does not support waiving the IMD exclusion for SMHRFs, we see benefit in such an approach for residential programs serving individuals in recovery from addictions.
- We support the inclusion of the following Designated Health Programs (DSHPs) for purposes of garnering federal matching funds:
    - workforce training;
    - residential and respite services for individuals with intellectual/developmental disabilities;
    - certain specialized and crisis response mental health services, such as triage, crisis stabilization, and transitional living programs operated by experienced community-based service providers;
- **Finally, and perhaps most critically, we recommend the Administration include stakeholders in negotiations with Federal CMS on the waiver application to ensure transparency and that recommendations are incorporated.**

Recommendations:

IARF provides the following recommendations for the next iteration of the waiver application. These recommendations are based on our review of existing waiver documents, review of the waiver process ongoing in other states, questions and answers from the stakeholder meetings (from participating stakeholders, Administration, staff, and HMA consultants), and the history of the relationship of community-based providers and the state of Illinois, both with respect to policy development and funding of services and supports.

<u>The inclusion of the specific recommendations below in the draft waiver application would ameliorate significant concerns of our organization and exhibit a commitment by the Administration in terms of acknowledging and working to address the concerns of the provider community tasked with serving individuals under the waiver.</u>

<u>Engagement Prior to Submitting the Waiver Application:</u>

- The Centers for Medicare & Medicaid Services (CMS) recently issued a Final Rule regarding home and community-based services (HCBS) that may require changes to how states define community. Furthermore, this rule gives states authority to make key changes to HCBS services. Although implementation is set to begin in March, CMS has indicated further guidance is forthcoming. It is in the best interest of the Administration to meet with key stakeholders to determine whether pursuing an 1115 waiver that includes individuals with intellectual/developmental disabilities is the best approach to ensure true person-centered services and supports and improved health outcomes in light of this Final Rule.

- Organize a time sensitive and outcome focused workgroup of key stakeholder organizations to draft service definitions. It is clear the definitions outlined in the draft waiver application are not inclusive of concerns from the provider community, specifically day habilitation, residential habilitation, temporary assistance, modifications, prevocational services, supported employment, and nursing.
- Meet with stakeholders participating in legislative efforts to revise authorized telehealth services to ensure the waiver application incorporates recommendations from these organizations where they are applicable to the Medicaid program, such as behavioral health.
- Community-based providers - similar to safety net hospitals - experience the effects of training costs and high staff turnover, but do not receive additional payments for serving a high Medicaid population. The Administration should commit to re-starting conversations with community-based providers on how it reimburses for training costs and to determine approaches where those training costs could be matched by the Medicaid program.
- Under state law pushed by community-based providers and supported by the Administration, a Management Improvement Initiative Committee was formed and has issued a series of recommendations to reduce administrative burdens, duplicative processes in oversight and management, and streamlined processes between the State and contractual providers. We encourage the Administration and HMA to review those recommendations for potential inclusion in the waiver application.
- We note the dearth of information in the draft waiver application with respect to the critical issues of prevention and treatment of substance use disorders (SUD). We encourage the Administration and consultants to thoroughly review comments provided to date from organizations such as IADDA, CBHA, and IARF for inclusion in the draft waiver application.

Written Recommendations for Inclusion in the Waiver Application:
Use of italics indicates provisions written into the current draft waiver application. Underlined and/or strikethrough indicate recommended changes.

To be added on page 5, under Improving access to community-based long-term service and supports Section:
- The 1115 Medicaid Waiver will in no way diminish or divert the total amount of existing resources currently invested in community-based services and supports for children and adults with intellectual and developmental disabilities, mental illnesses, and/or substance use disorders.
- Any additional savings and/or matching funds generated by the community-based system are reinvested back into the system.
- The waiver stated outcome to increase access to community-based services and supports is reinforced by a commitment to multi-year increases to rates and reimbursements to ensure true high-quality person-centered services and supports and a living wage for direct service personnel working in community-based agencies.

Modification to dot point two on page 7, under the Waiver Goals Section:
- *Increase flexibility*, ~~*and*~~ *choice*, and rates and reimbursements ~~*of*~~ for *long-term supports for adults and children and support development and expansion of choice within tiered levels of community-based options based on need*~~.~~ consistent with implementing true person-centered services and supports.

Modification to dot point three on page 7, under the same section:
- *Institute a provider assessment on residential habilitation providers to create greater access to home and community based residential services*, to the extent such an assessment - including methodology and investment of revenues - is fully negotiated with community-based provider organizations.

Modification to dot point five on page 7, under the same section:
- *Move the system away from facility-based* ~~*sheltered*~~ *work programs by promoting and fostering greater community-integrated, competitive employment opportunities*, while ensuring a full range of employment options are available to individuals with intellectual/developmental disabilities and mental illnesses with diverse wants, needs and skills.

To be added on page 12, following discussion of the Innovation and Transformation Resource Center:

- To the extent the Innovation and Transformation Resource Center intersects system changes affecting individuals with intellectual and developmental disabilities and mental illnesses, the Center will include staff with direct experience managing community-based programs and will incorporate the technical expertise of community-based providers.

Modification to paragraph two on page 25, under Health Care Workforce Loan Repayment:

- *The state is currently reviewing the existing loan repayment programs and will modify them as needed to ensure alignment with health care workforce needs. This may include adding additional professionals (e.g., social workers) that qualify for loan repayment and ensuring that all loan repayment programs are contingent on the recipient practicing in an underserved area.* Furthermore, the State will explore these programs to incentivize professionals to work in specific service settings, such as in community-based setting serving individuals with ID/DD and/or SMI.

To be added after page 30 under Pathway 4: LTSS Infrastructure, Choice, and Coordination Section:

- Working with stakeholders - including community-based providers, the Administration will identify both reimbursement and regulatory barriers that prevent community-based providers from downsizing facilities (ICFDD and CILA). Furthermore, the Administration commits to prioritizing rate models that incentivize community-based providers to create residential capacity that responds to the needs and wishes of individuals currently receiving services and those who will in the future.

To be added after page 33 under discussion of the Universal Assessment Tool (UAT):

- Should the Universal Assessment Tool (UAT) being developed through the Balancing Incentive Program (BIP) incorporate the assessment of need for long-term services and supports for individuals with intellectual and developmental disabilities, it will not be the final determinant of support needs nor rates and reimbursements that fund those support needs. The development and implementation of true person-centered services and supports will be collaborative and fully funded in rates and reimbursements.

Modification to paragraph four on page 34:

- *In addition, the state is developing a reimbursement rate methodology that will eliminate the rate disparities that exist across the nine waivers today. These changes will reduce and/or eliminate the service-level variability (where appropriate) and disparity that exists across populations and assist waiver providers in delivering the right service to the right person at the right time.* This process will include stakeholder engagement and will review and reference the existing reports and recommendations on improving and/or reforming rate methodologies for community-based services and supports. Furthermore, the Administration acknowledges the development and implementation of true person-centered services and supports will necessitate variability in terms of funding, as an individual's service and support needs are often unique and should not be limited by service tier and budgetary ranges.

Modification to paragraph one on page 35:

- *Emphasis will be placed on service planning and quality oversight of case management to ensure there is appropriate use and utilization of available services*, to the extent they are outlined in the individual's service plan and meet the person-centered service and support needs.

Modification to paragraph two on page 35:

- *Eligible waiver recipients will be assigned a service level tier based on their functional ability and support needs as determined by the UAT. Through the Universal Assessment Tool (UAT) the state will develop an institutional diversion process to emphasize Home and Community Based Services (HCBS) to determine when an individual on an institutional placement track may be more appropriately served in an HCBS setting*, to the extent the individual and/or family member(s)/guardian understands and requests this level of care.

Modification to paragraph three on page 35:

- *We believe the expanded array of services and resource allocation process will increase flexibility and improve satisfaction for individuals receiving services.* However, we acknowledge a commitment to developing and implementing true person-centered services and supports mandates variability in services and supports and funding of those services and supports.

Modification to paragraph one on page 36:

- *In order to reduce the waitlist and move individuals into services, Illinois will utilize a variety of mechanisms which may include: establishment of new priority criteria and identification of new funding sources and additional waiver slots.* In developing these mechanisms, the Administration will ensure meeting the service and support needs of the individual's primary diagnosis remains a priority, and that meeting health needs and or providing wraparound services does not remove an individual from the waitlist for services they have requested, unless otherwise specified by the individual/family member/guardian.

Modification to paragraph two on page 36, under Quality Incentive and Outcomes Section:

- *Illinois is seeking to adopt outcome-based reimbursement strategies to ensure that waiver recipients are not only receiving the right service at the right time* consistent with true person-centered services and supports*, but that high quality services and supports are being provided by qualified providers* to the extent they are adequately funded*. This quality incentive program will be developed in conjunction with stakeholders, including waiver recipients, families, providers, state staff, and other advocacy groups. While an incentive program will eventually be rolled out for all waiver populations, the State has opted to initially focus on outcomes for the ID/DD population. The State has identified areas for system-level improvement and will target incentive payments to increase:*
  - *Employment opportunities for waiver recipients;*
  - *Development of smaller residential settings in the community (four beds or less);*
  - *Consumer satisfaction;*
  - *Staff retention through wages and benefits and available training;*
  - *Community opportunities for persons with ID/DD.*

  Again, the Administration commits to working with the stakeholders outlined above on the development and implementation of any and all system-level improvement quality incentive programs, including those listed above.

Modification to paragraph three on page 36, same section:

- *The stakeholder group will develop a series of objectives and performance measures with benchmarks aimed at moving the system towards the State's goals. New and expanded quality incentive payments will be developed and implemented through a continuous quality improvement process. Areas for improvement will be constantly evaluated through quality improvement activities that:*
  - *Identify priority areas for improvement;*
  - *Establish outcome-based performance measures and appropriate target goals; and identify, collect, analyze and assess relevant data.*

  Consistent with the State's movement to Budgeting for Results, the Administration commits to not establishing any outcomes or performance measures unless the State provides adequate funding for such outcomes or performance measures. Furthermore, the Administration will not diminish or divert existing resources for community-based services and supports to provide funding for the system-level improvements identified in this Section without discussion and agreement with the stakeholders identified above.

Modification to paragraph two on page 37, under Waiver Consolidation: Integration of Behavioral Health:

- *...When referrals do occur, minimal coordination exists across the behavioral healthcare providers and HCBS Waiver providers.*The Administration notes that where this coordination does exist, it has been developed and implemented by providers despite restrictions on funding due to FFS arrangements.

Modification to the Health Homes for Adults with SMI Section starting on page 38:

- The Association recommends the application revise this section title to state: *Health Homes for Adults with SMI* and/or ID/DD

- The Association recommends this Section incorporate references to ID/DD where appropriate to advance the goals stated on page 20 of the Alliance for Health Plan, which seeks to advance medical homes for specific populations, including individuals with ID/DD

Modification to paragraph four on page 49, under Waiver and Expenditure Authority Requests Section:

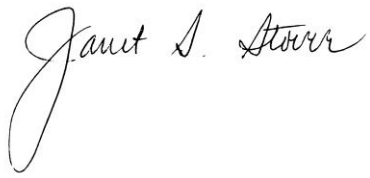
- *To allow for a provider assessment fee to be imposed on residential habilitation providers in the state to support rate increases ~~and to provide an additional financial incentive toward deinstitutionalization~~.*

The Administration is to be commended for envisioning a system where the Medicaid population has access to the care they need, in the amount they need, and delivered by qualified professionals and organizations. Illinois is cautioned, however, to approach the implementation and the phasing-in of such a vision with great care and consideration of the populations being included and the stress that most safety net providers have been under for several years.

We appreciate the opportunity to provide comments to you and your staff on this endeavor, and again express our concerns over the rapid timeframe in which this application has and continues to be developed. We believe it is in the best interests of all stakeholders that, should this process move forward, it be driven by the need to develop a high quality Medicaid program that provides true person-centered services and supports, not an arbitrary timeline.

My staff and I stand ready to discuss the entirety of this document with you at your convenience.

Sincerely,



Janet S. Stover,
President/CEO

CC: Carl LaMell, Chair, IARF Board of Directors
Cristal Thomas, Deputy Governor
Michael Gelder, Senior Advisor on Health Policy, Office of the Governor
Julie Hamos, Director, Department of Healthcare and Family Services
Michelle Saddler, Secretary, Department of Human Services